REINSTATEMENT NOTICE

County Name
County Address
County City State Zip

WKR ID: (Worker ID) SVC LOC: (County)
(Enrollee Name)
(Notice Mailed Date) (Enrollee Address)
(Enrollee City / State / Zip)

HEALTH PLAN REINSTATEMENT NOTICE

Recipient ID: (PMI) Name: (Enrollee Name)
Case Number: (Case #)
Start Date: (Reinstatement Effective Date)
Health Plan: (Health Plan Name) Program: (MA)

Your enrollment in (health plan name) will continue as of (reinstatement effective date).

Please ignore the health plan disenrollment letter which ended your health plan enrollment on (disenrollment date).

Continue to get all of your health care from (health plan name). Any health care not approved or given by this plan will not be covered. This means you may have to pay the bill. Check with your health plan if you have any questions. Your health plan Member Services number is printed on the back of your health plan card.

Your health plan might change your primary care clinic. Call your health plan's Member Services to make sure you can go to the clinic you want. Then, use this clinic for all your health care.

This information is available in other forms to peoples with disabilities by contacting us at 651-296-3386 (voice), or toll free at 1-800-657-3756. TDD users can call the Minnesota Relay at 711 or 1-800-627-3529. For the Speech-to-Speech Relay, call 1-877-627-3838.